Professional Counseling Center, PLLC

Please Print

Patient's Full Legal Name: _____ Intake Date: _____Time:_____

Patient SS#:_____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Employer: _____ Source of Referral: _____

Home Phone: _____ Work Phone: _____ Other _____

Email: _____ Driver's license # and Issuing State: _____

Responsible Person's Legal Name: _____

Patient's Legal Guardian Name if a Minor: _____

Responsible Person's SS#:_____ Date of Birth: _____/_____/_____

Responsible Person's Employer_____

Name of Primary Insurance Company:_____

Primary Insurance Policy Holder:_____

Policy Holder SS#: _____ Date of Birth: _____/_____/_____

Insurance Address:_____ City:_____ State:____ Zip:_____

Phone Number:_____ Subscriber ID # :_____ Employer/Group Number: _____

Prior Authorization Number (If Required):_____ Number of Sessions Authorized: _____

PROVISIONS: Patient pays $_____ Deductible Amount Co-Payment: $_____

Secondary Insurance Policy Holder:_____

Policy Holder SS#: _____ Date of Birth: _____/_____/_____

Name of Secondary Insurance Company:_____

Address:_____City:_____ State:_____ Zip:_____

Phone Number: _____ Subscriber ID #:_____ Employer/Group Number: _____

Prior Authorization Number (If Required):_____Number of Sessions Authorized: _____

PROVISIONS: Patient pays $_____ Deductible Amount Co-Payment: $_____

Payment method (Insurance and cash clients; deductibles, co-payments, etc.)

___ Check ___ Cash ___ Credit Card (type) Master Card Visa American Express

Cardholder name: _____ Number: _____

Expiration Date_____/_____ (mmyy) Last 3 digits on the back of card _____

INFORMED CONSENT FOR PSYCHOTHERAPY

Important issues regarding confidentiality need to be understood as we begin our work together. Please review this material carefully so that we may discuss any questions or concerns of yours the next time we meet.

In general, the confidentiality of all communications between a patient and psychologist is protected by law, and I can only release information about our work to others with your written permission. There are a few exceptions, however.

In most judicial proceedings you have the right to prevent me from testifying. However, in child custody proceedings, adoption proceedings, and proceedings in which your emotional condition is an important element, a judge may require my testimony if it is determined that resolution of the issues before the court requires it. If you are involved in litigation, or are anticipating litigation, and you choose to include your mental or emotional state as part of the litigation, I may have to reveal part or all of your treatment or evaluation records.

If you are called as a witness in criminal proceedings, opposing counsel may have some limited access to your treatment records. Testimony may also be ordered in (a) legal proceeding relating to psychiatric hospitalization; (b) in malpractice and disciplinary proceedings brought against a psychologist; (c) court-ordered psychological evaluations; and (d) certain legal cases where the client has died.

In addition, there are some circumstances when I am required to breach confidentiality without a patient's permission. This occurs if I suspect the neglect or abuse of a minor, in which case I must file a report with the appropriate State agency. If, in my professional judgment, I believe that a patient is threatening serious harm to another, I am required to take protective action which may include notifying the police, warning the intended victim, or seeking the client's hospitalization. If a client threatens to harm himself or herself, I may be required to seek hospitalization.

The clear intent of these requirements is that a psychologist has both a legal and ethical responsibility to take action to protect endangered individuals from harm when his or her professional judgment indicates that such danger exists. Fortunately, these situations rarely arise in my practice.

There are several other matters concerning confidentiality:

1. I may occasionally find it helpful or necessary to consult about a case with another professional. In these consultations I make every effort to avoid revealing the identity of the client. The consultant is, of course, also legally bound to maintain confidentiality. If I feel that it would be helpful to refer you to another professional for consultation then, of course, with your authorization, I will discuss your case with her or him.

2. I am required to maintain complete treatment records. Patients are entitled to receive a copy of these records, unless I believe the information would be emotionally damaging and, in such cases, the records must be made available to the patient's appropriate designee. Patients will be charged an appropriate fee for preparation.
3. If you use third party reimbursement, I am required to provide the insurer with a clinical diagnosis and sometimes a treatment plan or summary. If you request it, I will provide you with a copy of any report which I submit.

4. If you are under eighteen years of age, please be aware that while the specific content of our communications is confidential, your parents have a right to receive general information on the progress of the treatment.

5. Under current Texas law, in group and family therapy and in marital therapy all participants are required to consent to the release of information. One marital partner may not waive privilege for another. In cases of marital therapy, therefore, the record may be released only if both parties waive privilege or release of the record is court ordered.

While this summary of exceptions to confidentiality should prove helpful in informing you about potential problems, you should be aware that the laws governing these issues are often complex and I am not an attorney. I encourage our active discussion of these issues. However, if you need more specific advice, formal legal consultation may be desirable. If you request, I will provide you with relevant portions or summaries of the applicable State laws governing these issues.

I have read the above; fully understand the diagnosis, the nature of treatment, the alternatives to this treatment, the limits of confidentiality in this relationship, and the circumstances in which confidential communications may need to be breached.

_____ _____
Signature Date

_____ _____
Witness Date

Limits of Confidentiality

The contents of a counseling intake or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this clinic not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client disclosed intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Clients Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic.

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information which may be requested includes types of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In some cases, notes and reports are dictated/typed within the clinic or by outside sources specializing (and held accountable) for such procedures..

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. The information includes: (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other resources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjunct family or couple sessions, in which each party disclosed such information in each other's presence, is kept in each file in the form o f case notes.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Please check where you may be reached by phone. Include phone numbers and how you would like us to identify ourselves when phoning you.

_____ HOME Phone Number: _____

How should we identify ourselves?_____

May we say the clinic name? _____ Yes _____ No

_____ WORK Phone Number: _____

How should we identify ourselves?_____

May we say the clinic name? _____ Yes _____ No

_____ OTHER Phone Number: _____

How should we identify ourselves?_____

May we say the clinic name? _____ Yes _____ NO

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client name (please print):_____

Client (or guardians) signature:_____ Date:_____/_____/_____

Financial Policy

The staff at the Professional Counseling Center, PLLC, (hereafter referred to as the clinic), are committed to providing caring and professional mental health to all of our clients. As part of the delivery of mental health services, we have established a financial policy which provides payment policies and options to all consumers. The financial policy of the clinic is designed to clarify the payment policies as determined by the management of the clinic.

The *Person Responsible for Payment of Account* is required to sign the form, **Payment Contract for Services**, which explains the fees and collection policies of the clinic. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, the clinic will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services not as reasonable or not necessary or may determine that services are not covered. In such cases, the *Person Responsible for Payment of Account* is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

Payments not received at the time of service are subject to collections. A 1% per month interest rate is charged for accounts over 30 days. The *Person Responsible for Payment of account* (as noted in the **Payment Contract for Services**) will be financially responsible for payment of such services. The *Person Responsible for Payment of Account* is financially responsible for paying funds not paid by insurance companies or third-party payers.

Insurance deductibles and co-payments are due at the time of service. Although it is possible the mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the clinic), this amount will be collected by the clinic until the deductible payment is verified to the clinic by the insurance company or third-part provider.

All insurance benefits will be assigned to this clinic (by insurance company or third-party provider) unless the *Person Responsible for Payment of Account* pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied non-emergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the **Payment Contract for Services**.

Payment methods include check, cash, or the following charge cards: Master Card, Visa, and American Express. Clients using charge cards may either use their card at each session or sign a document allowing the clinic to automatically submit charges to the charge card after each session.

Questions regarding the financial policies can be answered by the Office Manager.

I (we) have read, understand, and agree with the provisions of the **Financial Policy**.

Person Responsible for Account:_____ Date:_____/_____/_____

Co-responsible party:_____ Date:_____/_____/_____

Payment Contract for Services

Name: _____

Address:_____ City:_____ State:_____ Zip:_____

Bill to: Personal Responsible for Payment of Account:_____

Address:_____ City:_____ State:_____ Zip:_____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One - Fees for Professional Services

I (we) agree to pay the Professional Counseling Center, PLLC, hereafter referred to as the clinic, a rate of **$120.00** per clinical unit (defined as 45-50 minutes for assessment, testing, and individual, family, and relationship counseling).

A fee of **$45.00** is charged for group counseling. The fee for testing includes scoring and report-writing time.

A fee of **$120.0**0 is charged for missed appointments or cancellations with less than 24 hours notice.

Part Two - Clients with Insurance (Deductible and Co-Payment Agreement)

This clinic has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated Insurance Benefits

1) $_____Deductible amount (paid by insured party)
2) Co-payment % _____ ($ _____/clinical unit) for first _____ visits.
3) Co-payment % _____ ($ _____/clinical unit) up to _____ visits.
4) The policy limit is _____ per year: _____ annual _____ calendar

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services that are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be non-efficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

Person responsible for account:_____
Date:____/____/___

Part Three - All Clients

Payment, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account:_____ Date:_____/_____/_____

Release of Information Authorization to Third Party

I(we) authorize the Professional Counseling Center, PLLC to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payers or insurance company for the purpose of receiving payment directly to the Professional Counseling Center, PLLC.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account:_____ Date:_____/_____/_____

Person(s) receiving services: _____ Date:_____/_____/_____

Person(s) or guardian(s):_____ Date:_____/_____/_____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE OF THE PROFESSIONAL COUNSELING CENTER, PLLC

The undersigned acknowledges having received a copy of the Privacy Notice of the Professional Counseling Center, PLLC privacy practices as of the date noted below.

_____ _____

Signature of Patient or Legal Representative Date

If signed by Legal Representative, please describe the authority of Legal Representative to sign for patient.